SUPPLEMENTAL SHEET

FACILITY
NAME: _____
ADDRESS:_____
_____

TELEPHONE: ( ) _____

RADIATION SAFETY PERSON (RSO)
NAME: _____
ADDRESS:_____
_____

TELEPHONE: ( ) _____

RADIATION MACHINE
MANUFACTURER: _____
_____

MODEL NUMBER: _____
CONSOLE SERIAL: _____
TUBE SERIAL: _____
RATING - MAX. kVp: _____
MAX. mA: _____
SUPPLIER: _____
INSTALLER: _____
SERVICE AGENT: _____
[1] STATIONARY
[2] PORTABLE
[3] MOBILE
GEOG. LOCATION: _____

ADMINISTRATOR/MACHINE OWNER
NAME: _____
ADDRESS:_____
_____

TELEPHONE: ( ) _____
SIGNATURE: _____
Date Form Completed:_____

TYPE OF PRACTICE

[1]	Medical	[7]	Schools
[2]	Dental	[8]	Hospital
[3]	Podiatric	[9]	Mammographic
[4]	Chiropractic	[10]	Colleges
[5]	Industrial	[11]	OTHER
[6]	Veterinary	[12]	State owned and operated

FACILITY SUPERVISOR
NAME: _____
SIGNATURE: _____

RADIATION MACHINE
TYPE OF MACHINE:
[1] Dental
[2] Radiographic
[3] Fluoroscopic
[4] Intensifier
[5] Computerized Tomography
[6] Cephalometric
[7] Panographic
[8] Combination Fluoro - Radiographic
[9] Therapy
[10] Industrial
[11] OTHER
[12] Mammographic
[13] Bone Densitometry

ROOM # _____

INSPECTION
DATE OF LAST INSPECTION: _____
INSPECTED BY WHOM: _____
_____
[ ] NEVER INSPECTED

OFFICE USE ONLY:

FACILITY ID #: _____
RECEIPT #: _____
AMOUNT: _____
REGISTRATION #: _____
EXPIRATION DATE: _____
TOTAL # OF TUBES: _____